The Collaborative Assessment and Management of Suicidality (CAMS)

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Evidence-Based Treatments for Suicidality

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

National Institutes of Health
National Institute of Mental Health
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Bethesda, Maryland 20892

Opportunities to Improve Interventions to Reduce Suicidality: Civilian "Best Practices" for Army Consideration*

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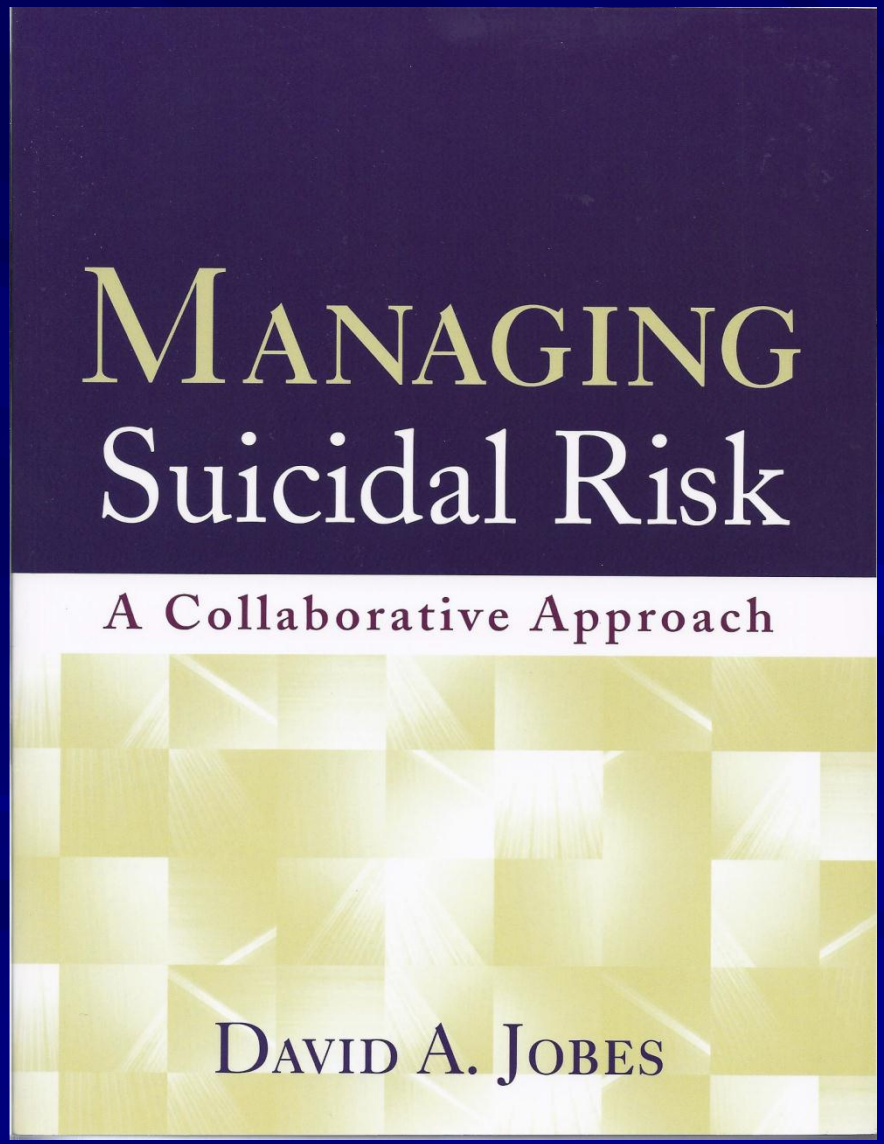
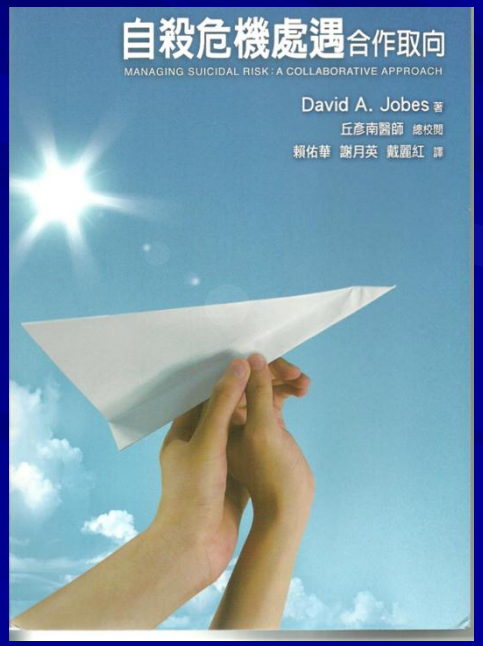
The views expressed in this document do not necessarily represent the views of the National Institute of Mental Health, the National Institutes of Health, the Department of Health and Human Services, or the United States government.

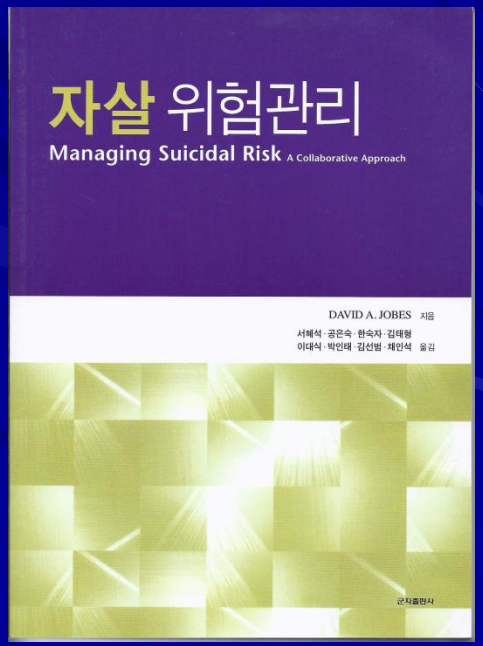
* This document was developed in support of the US Army's ongoing efforts to reduce suicides and suicidality among Army Soldiers, and submitted to General Peter Chiarelli, Vice Chief of Staff of the Army, in December 2009. An earlier version of this document was submitted to Mr. Robert Andrews, Special Assistant to the Secretary of the Army, and General Chiarelli, in May 2009. The current version has been updated and somewhat expanded, in particular by adding a section on quality assurance and performance metrics (Section III).

- With n=50 studies (in the world literature), there are remarkably few evidence-based treatments and interventions for suicidal risk
- We mostly know what does not work (e.g., medication only)
- What does work:
  - Dialectic Behavior Therapy (DBT)
  - Cognitive Therapy
  - Brief interventions with non-demand follow-up

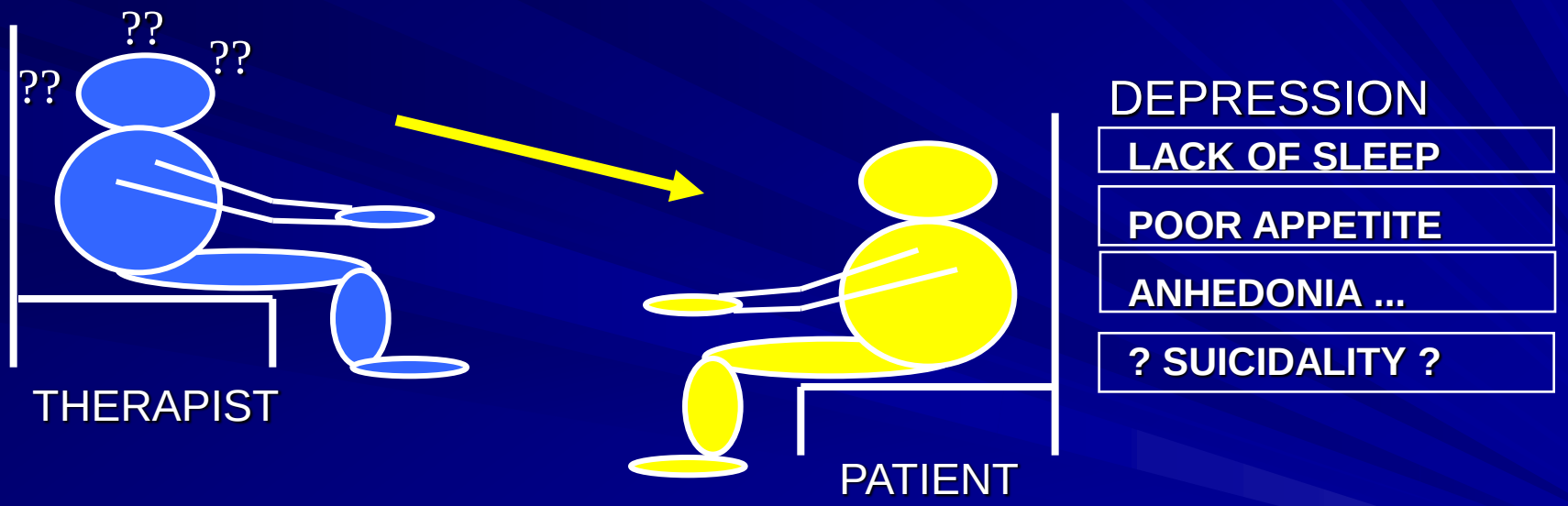
The Collaborative Assessment and Management of Suicidality (CAMS)





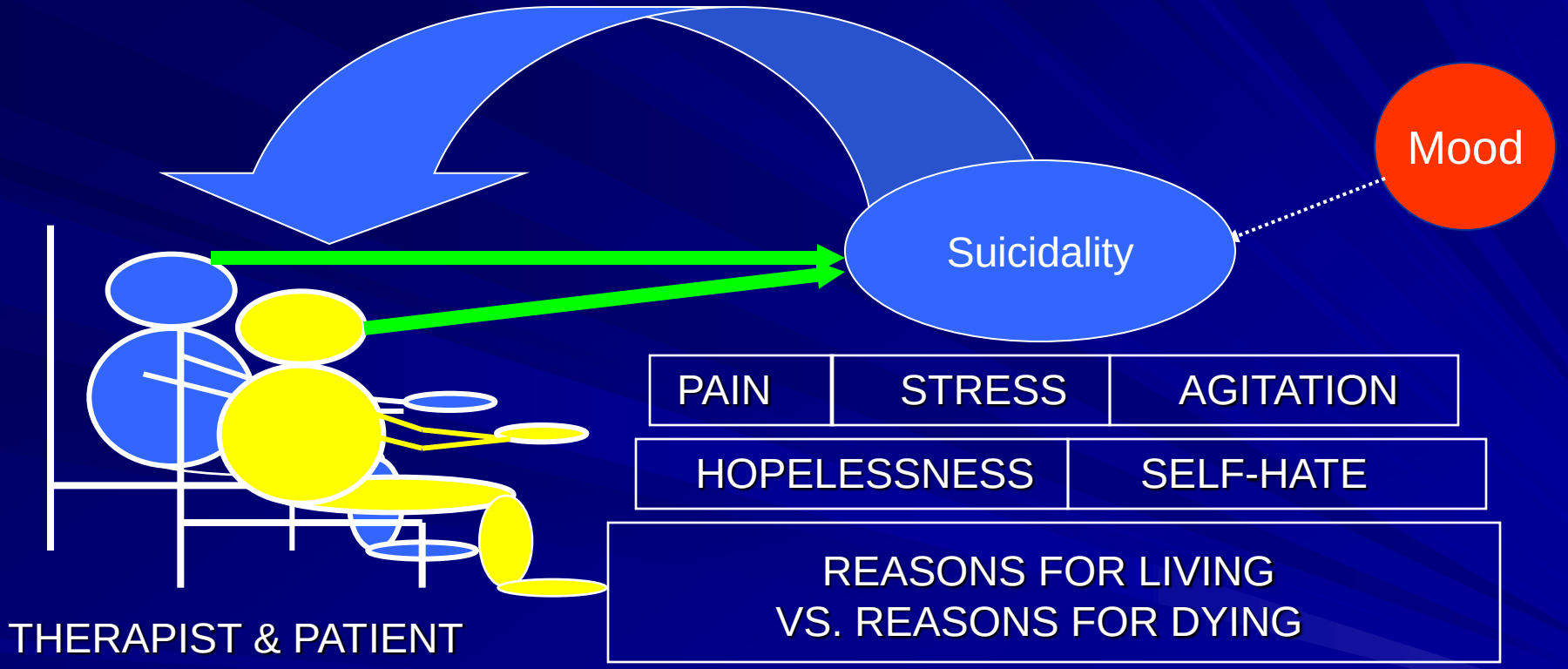


Critique of Current Approach to Suicide Risk: THE REDUCTIONISTIC MODEL (Suicide = Symptom of Psychopathology)

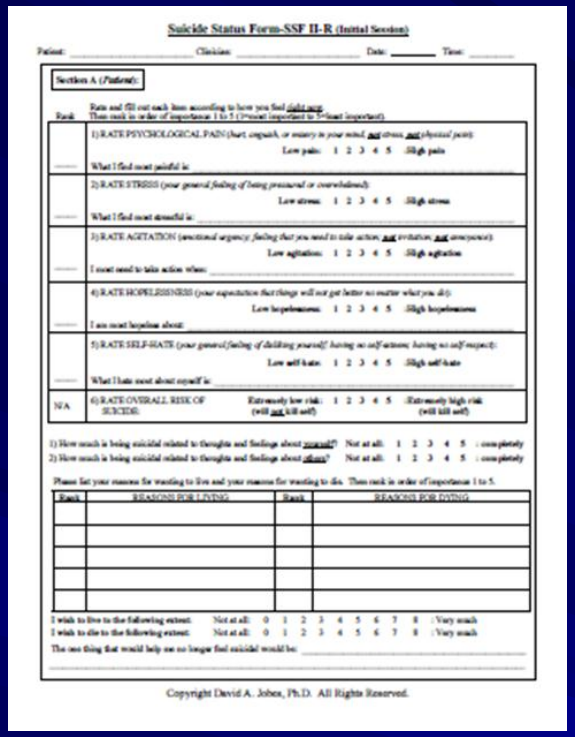


Traditional treatment = inpatient hospitalization, treating the psychiatric disorder, and using no suicide contracts…

The Collaborative Assessment and Management of Suicidality (CAMS) identifies and targets ***Suicide*** as the primary focus of assessment and intervention…



CAMS assessment uses the Suicide Status Form (SSF) as a means of deconstructing the “functional” utility of suicidality; CAMS as an intervention emphasizes a problem-focused intensive outpatient approach that is suicide-specific and “co-authored” with the patient…



Suicide Status Form-SSF II-R (Initial Session)

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient):

Rank: Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1=most important to 5=least important).

_____ 1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, not stress, not physical pain*):
Low pain: 1 2 3 4 5 :High pain
What I feel most painful is: _____

_____ 2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):
Low stress: 1 2 3 4 5 :High stress
What I feel most stressful is: _____

_____ 3) RATE AGITATION (*emotional urgency; feeling that you need to take action, not evitation, not annoyance*):
Low agitation: 1 2 3 4 5 :High agitation
I most need to take action when: _____

_____ 4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):
Low hopelessness: 1 2 3 4 5 :High hopelessness
I am most hopeless about: _____

_____ 5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):
Low self-hate: 1 2 3 4 5 :High self-hate
What I hate most about myself is: _____

N/A 6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)

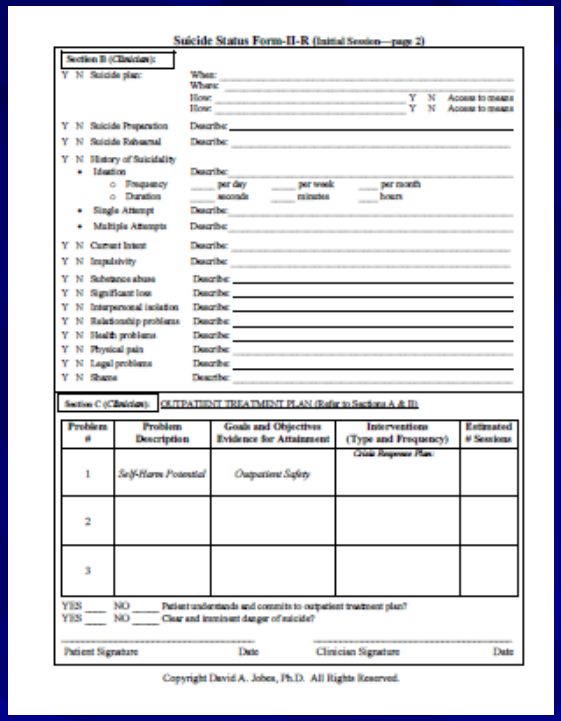
1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 : completely
2) How much is being suicidal related to thoughts and feelings about others? Not at all: 1 2 3 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 :Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 :Very much

The one thing that would help me no longer feel suicidal would be: _____



Suicide Status Form-II-R (Initial Session—page 2)

Section B (Clinician):

Y N Suicide plan: When: _____ Where: _____ How: _____ Y N Access to means How: _____ Y N Access to means
Y N Suicide Preparation Describe: _____
Y N Suicide Rehearsal Describe: _____
Y N History of Suicidality
- Ideation
  - Frequency ____ per day ____ per week ____ per month
  - Duration ____ seconds ____ minutes ____ hours
- Single Attempt Describe: _____
- Multiple Attempts Describe: _____

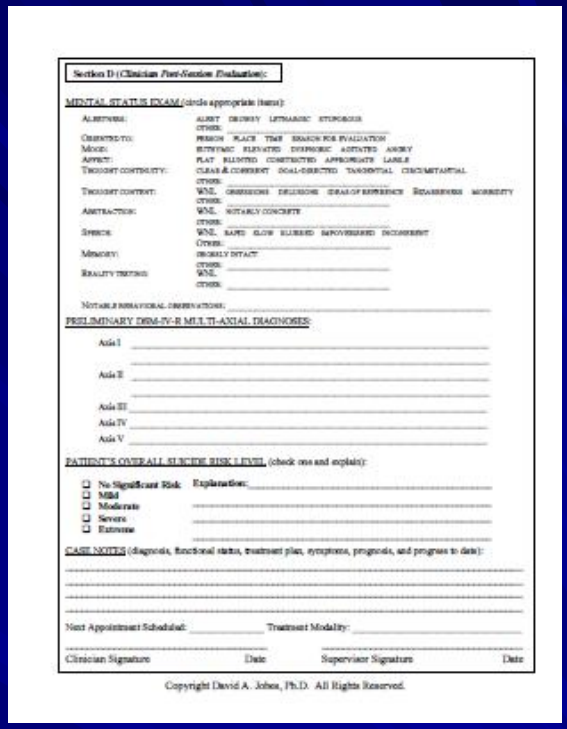
Y N Current Intent Describe: _____
Y N Impulsivity Describe: _____
Y N Substance abuse Describe: _____
Y N Significant loss Describe: _____
Y N Interpersonal isolation Describe: _____
Y N Relationship problems Describe: _____
Y N Health problems Describe: _____
Y N Physical pain Describe: _____
Y N Legal problems Describe: _____
Y N Shame Describe: _____

Section C (Clinician): OUTPATIENT TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency) *Crisis Response Plan*	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*		
2				
3				

YES ___ NO ___ Patient understands and commits to outpatient treatment plan?
YES ___ NO ___ Clear and imminent danger of suicide?

_____ Patient Signature Date _____ Clinician Signature Date



Section D (Clinician *Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS OTHER:
ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION
MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER:
THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE HOMICIDALITY SUICIDALITY OTHER:
ABSTRACTION: WNL NOTABLY CONCRETE OTHER:
SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER:
MEMORY: GROSSLY INTACT OTHER:
REALITY TESTING: WNL OTHER:
NOTABLE BEHAVIORAL OBSERVATIONS: _____

PRELIMINARY DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

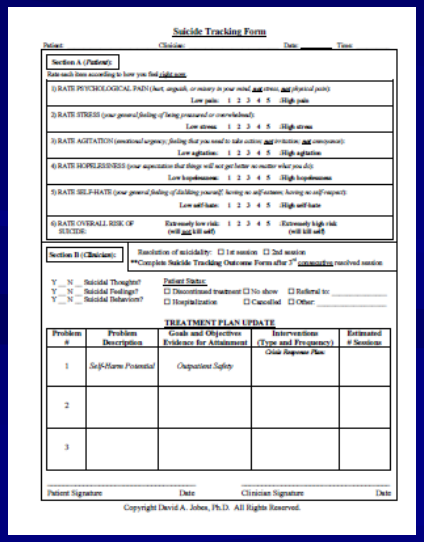
☐ No Significant Risk Explanation: _____
☐ Mild _____
☐ Moderate _____
☐ Severe _____
☐ Extreme _____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ Clinician Signature Date _____ Supervisor Signature Date



Suicide Tracking Form

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, not stress, not physical pain*):
Low pain: 1 2 3 4 5 :High pain

2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):
Low stress: 1 2 3 4 5 :High stress

3) RATE AGITATION (*emotional urgency; feeling that you need to take action, not evitation, not annoyance*):
Low agitation: 1 2 3 4 5 :High agitation

4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):
Low hopelessness: 1 2 3 4 5 :High hopelessness

5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):
Low self-hate: 1 2 3 4 5 :High self-hate

6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)

Section B (Clinician): Resolution of suicidality: ☐ 1st session ☐ 2nd session
**Complete Suicide Tracking Outcome Form after 3rd consecutive resolved session

Y __ N __ Suicidal Thoughts? Patient Status:
Y __ N __ Suicidal Feelings? ☐ Discontinued treatment ☐ No show ☐ Referral to: _____
Y __ N __ Suicidal Behaviors? ☐ Hospitalization ☐ Cancelled ☐ Other: _____

TREATMENT PLAN UPDATE

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency) *Crisis Response Plan*	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*		
2				
3				

_____ Patient Signature Date _____ Clinician Signature Date

Section C (Clinician *Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS OTHER:
ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION
MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER:
THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE HOMICIDALITY SUICIDALITY OTHER:
ABSTRACTION: WNL NOTABLY CONCRETE OTHER:
SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER:
MEMORY: GROSSLY INTACT OTHER:
REALITY TESTING: WNL OTHER:
NOTABLE BEHAVIORAL OBSERVATIONS: _____

DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

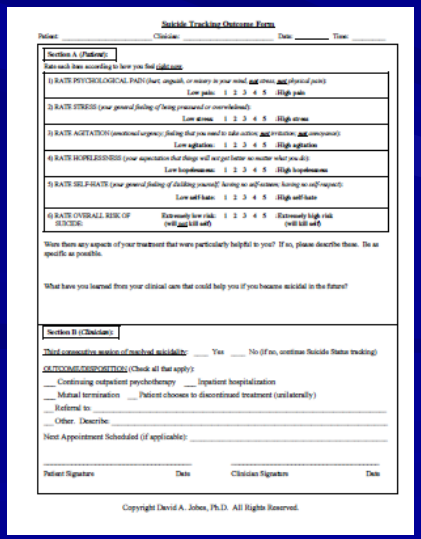
☐ No Significant Risk Explanation: _____
☐ Mild _____
☐ Moderate _____
☐ Severe _____
☐ Extreme _____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ Clinician Signature Date _____ Supervisor Signature Date



Suicide Tracking Outcome Form

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, not stress, not physical pain*):
Low pain: 1 2 3 4 5 :High pain

2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):
Low stress: 1 2 3 4 5 :High stress

3) RATE AGITATION (*emotional urgency; feeling that you need to take action, not evitation, not annoyance*):
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Low hopelessness: 1 2 3 4 5 :High hopelessness

5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):
Low self-hate: 1 2 3 4 5 :High self-hate

6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)

Were there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.

What have you learned from your clinical care that could help you if you became suicidal in the future?

Section B (Clinician):

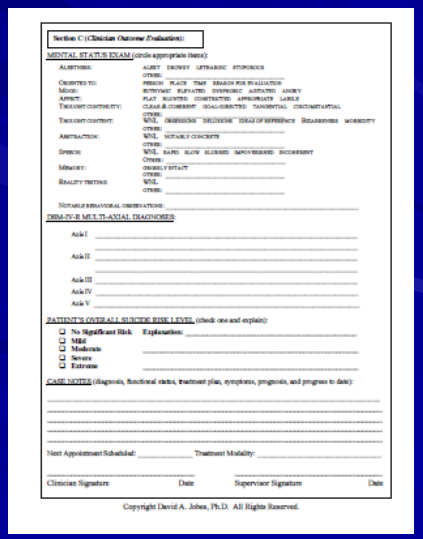
Third consecutive session of resolved suicidality: ___ Yes ___ No (if no, continue Suicide Status tracking)

OUTCOME DISPOSITION: (Check all that apply):

___ Continuing outpatient psychotherapy ___ Inpatient hospitalization
___ Mutual termination ___ Patient chooses to discontinued treatment (unilaterally)
___ Referral to: _____
___ Other. Describe: _____

Next Appointment Scheduled (if applicable): _____

_____ Patient Signature Date _____ Clinician Signature Date



Section C (Clinician *Outcome Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

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REALITY TESTING: WNL OTHER:
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DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I _____
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Axis III _____
Axis IV _____
Axis V _____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ No Significant Risk Explanation: _____
☐ Mild _____
☐ Moderate _____
☐ Severe _____
☐ Extreme _____

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____ Clinician Signature Date _____ Supervisor Signature Date

Psychometrics of the Core SSF (Jobes et al., 1997; Conrad et al., 2009)

TABLE 3
Convergent Validity: Correlations Between SSF-II Items and Established Measures of Similar Constructs

SSF-II Item	Measure	*n*	Spearman rho
Pain	BHQ-20	113	–.35*
	OQ-45.2	127	.45*
	OMMP	110	.43*
Stress	PI-III	129	.12
	STICSA-S	130	.36*
	STICSA-T	136	.27*
	STICSA-Total	121	.31*
Agitation	STICSA-S	128	.42*
	STICSA-T	134	.28*
	STICSA-Total	119	.36*
	BIS	133	.36*
Hopelessness	BHS	140	.52*
Self-hate	BST	141	–.37*
Overall Risk	L-RFL	137	–.51*

Note. *Correlation is significant at $p < .01$ (one-tailed).

TABLE 2
Factor Analysis Results: Spearman Promax Rotated Factor Pattern

SSF-II Item	Factor 1	Factor 2
Self-hate	.88***	–.09
Hopelessness	.85***	.05
Pain	.74***	.10
Agitation	–.07	.92***
Stress	.12	.78***

Note. ***Value is greater than 0.4

TABLE 5
Comparison of Suicidal Patients to Nonsuicidal Patients on SSF-II Items

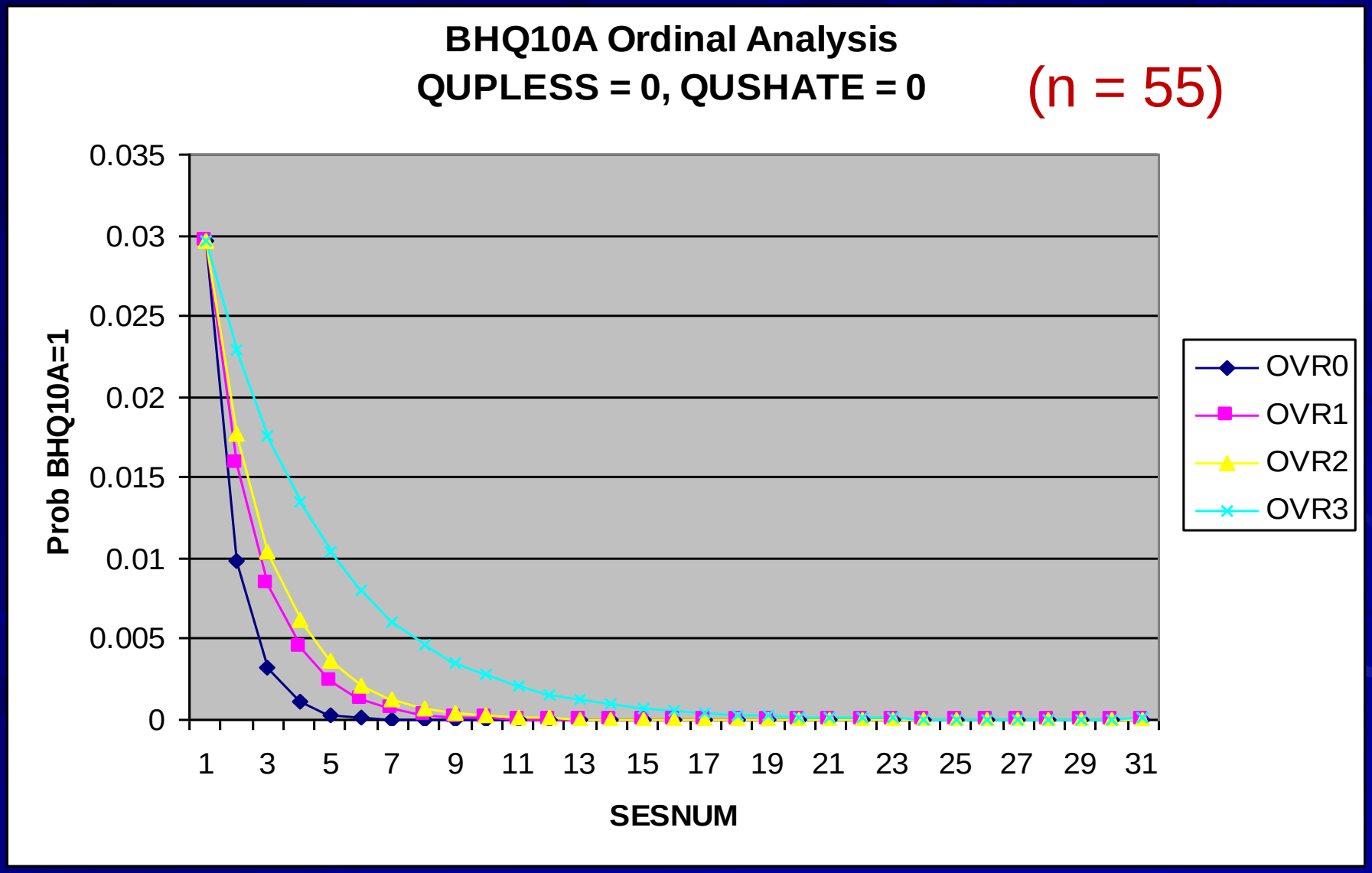
	Suicidal patients		Nonsuicidal patients		Univariate
SSF item	*M*	*SD*	*M*	*SD*	*F*
Pain	3.82	1.24	3.44	1.34	2.644
Stress	3.87	1.25	3.78	1.35	0.133
Agitation	2.90	1.24	2.93	1.39	0.018
Hopelessness	3.81	1.29	2.83	1.41	16.030**
Self-hate	3.74	1.31	2.88	1.44	12.083**
Overall risk	2.68	1.27	1.55	0.77	28.467**
OQ-45 total	125.22	23.13	130.47	26.10	1.63

Note. **F statistic is significant at $p < .001$.

Reliability

The first three test-retest t-test analyses yielded correlations that were statistically significant (Pain = .33, Stress = .23, Agitation = .35); however, the findings were more robust for the latter three variables (Hopelessness = .46; Self-Hate = .57, Overall Risk = .51). All correlations were significant at the $p < .001$ level, except the SSF *stress* correlation, which was significant at $p < .05$.

Index SSF Overall Risk rating differentially predicted four different reductions in suicidal thoughts…



RFL/RFD Cross Sectional Results (n=108) (Jobes, Stone, & Wagner, 2010)

Measures	RFL	AMB	RFD	Test
Beck Hopelessness Scale	10.17	12.62	15.01	*F* = 5.23**
Reasons for Living Inventory	179.00	141.88	148.53	*F* = 5.14**
WTL/WTD Suicide Index Score	3.49	1.83	-2.03	*F* = 18.24***

Suicide Attempts	RFL	AMB	RFD	Test
0-1 Attempts	15	10	6	
2 or more Attempts	5	11	15	Chi-Sq = 7.83*

* p < .05, ** p < .01, *** p < .001

Adherence to CAMS as an Intervention: (Jobes, Comtois, Brenner, & Gutierrez, 2011)

CAMS is a *therapeutic framework*, used until suicidality resolves. Adherence to CAMS requires thorough suicide assessment and problem-focused interventions that are designed to target and treat direct and indirect "*drivers*" of suicide risk.

CAMS as a Therapeutic Philosophy

1. Collaboration
   - Empathy with the suicidal wish
   - Clarify the CAMS agenda
   - All assessments/interventions are interactive
2. Suicide-focus ultimately guides all therapeutic activity

CAMS as a Clinical Framework

1. Assess index and on-going suicide risk using the SSF
2. All SSF-guided interventions are meant to eliminate direct or indirect causes of suicidal risk
   - A suicide-specific treatment plan with Crisis Response/Safety Plan
   - Reduce access to lethal means
   - Insure treatment attendance
   - Make referrals to address indirect causes of suicide

Overview to CAMS Assessment and Care

CAMS is a suicide-specific therapeutic framework, emphasizing five core components of collaborative clinical care (over 10-12 sessions/3 months).

- Component I. Collaborative Assessment of Suicidal Risk

- Component II. Collaborative Treatment Planning
  - → Attend treatment reliably as scheduled over the next three months
  - → Reduce access to lethal means
  - → Develop and use a Coping Card as part of Crisis Response Plan
  - → Create interpersonal supports

- Component III. Collaborative Deconstruction of Suicidogenic Problems
  - → Relationship issues (especially family)
  - → Vocational issues (what do they do?)
  - → Self-related issues (self-worth/self-esteem)
  - → Pain and suffering—general and specific

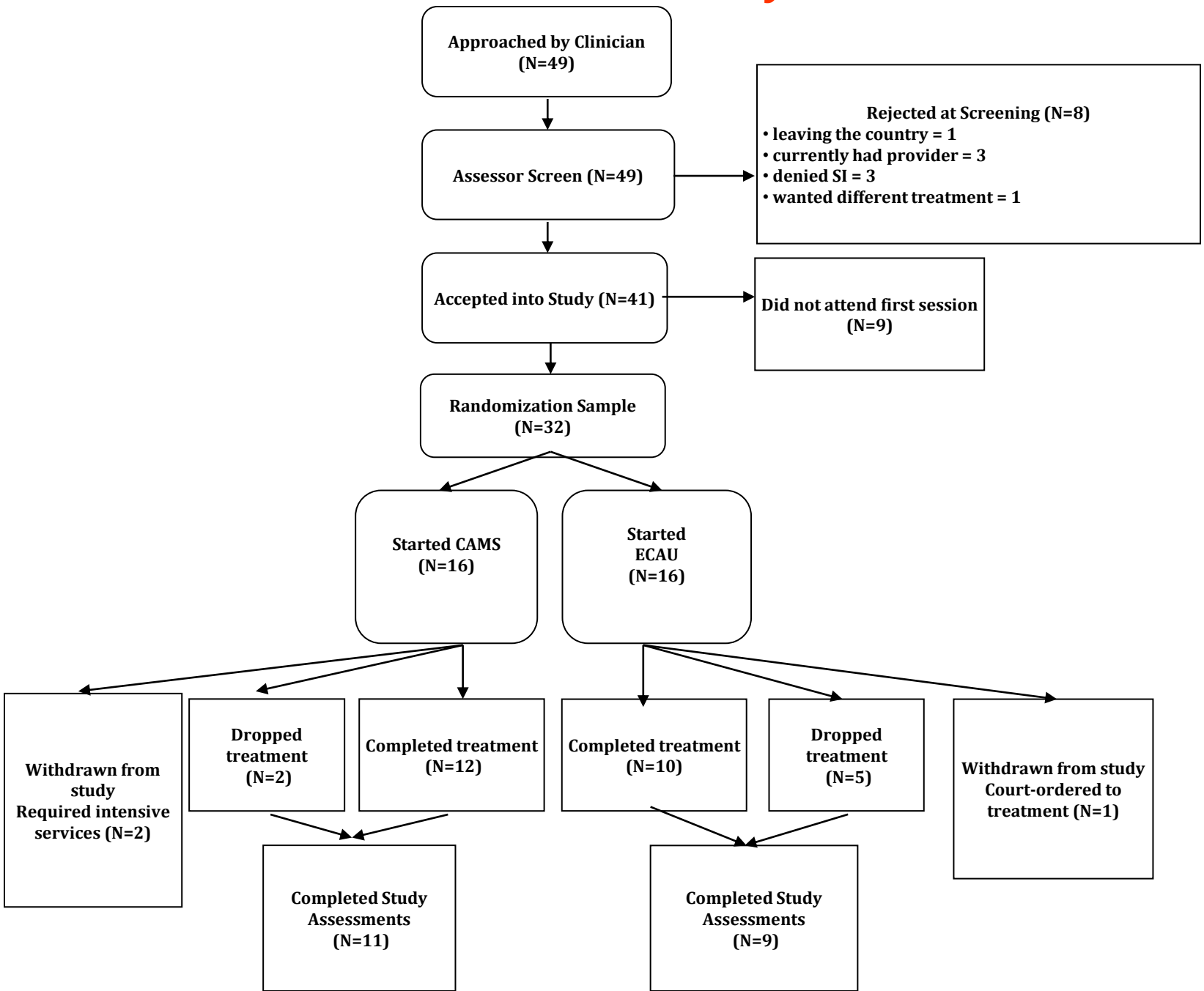
- Component IV. Collaborative Problem-Focused Interventions

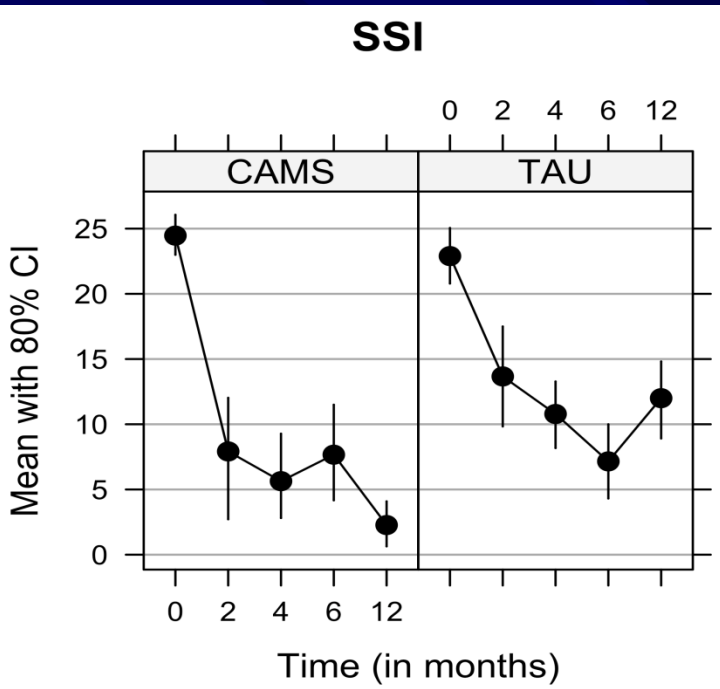
- Component V. Collaborative Development of Reasons for Living
  - → Develop plans, goals, and hope for the future
  - → Develop guiding beliefs

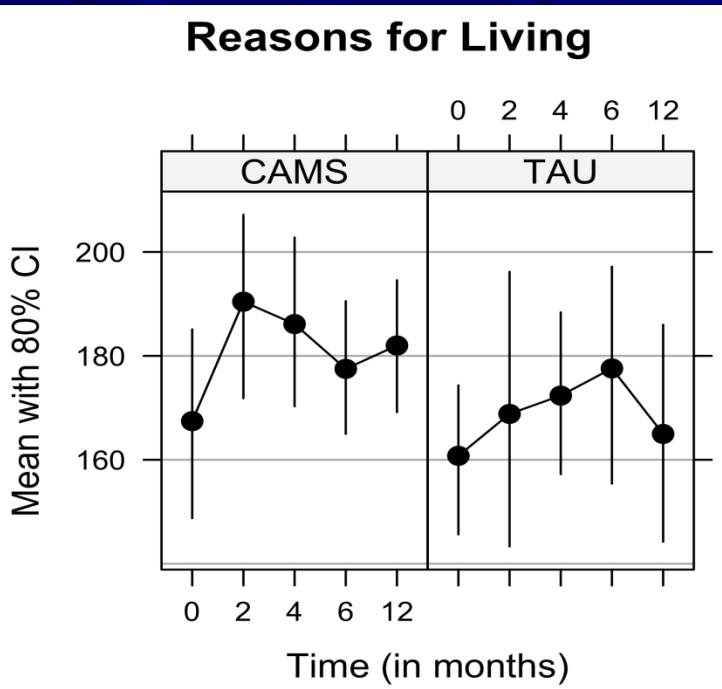
Correlational Support for SSF/CAMS

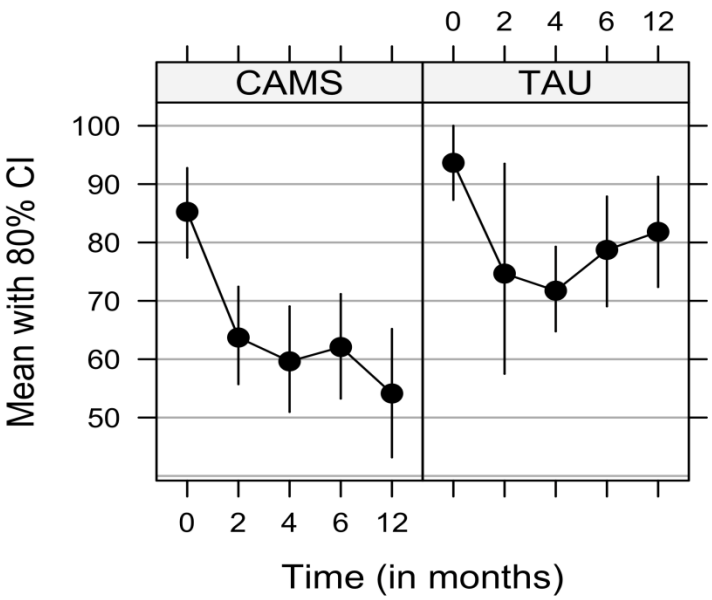
Authors	Sample/Setting	n =	Significant Results
Jobes et al., 1997	College Students Univ. Counseling Ctr.	106	Pre/Post Distress Pre/Post Core SSF
Jobes et al., 2005	Air Force Personnel Outpatient Clinic	56	Between Group Suicide Ideation, ED/PC Appts.
Arkov et al., 2008	Danish Outpatients CMH Clinic	27	Pre/Post Core SSF Qualitative findings
Jobes et al., 2009	College Students Univ. Counseling Ctr.	55	Linear reductions Distress/Ideation
Nielsen et al., 2011	Danish Outpatients CMH Clinic	42	Pre/Post Core SSF
Ellis et al., 2012	Psychiatric Inpatients	20	Pre/Post Core SSF Ideation, Depression, Hopeless, Suic. Cog.

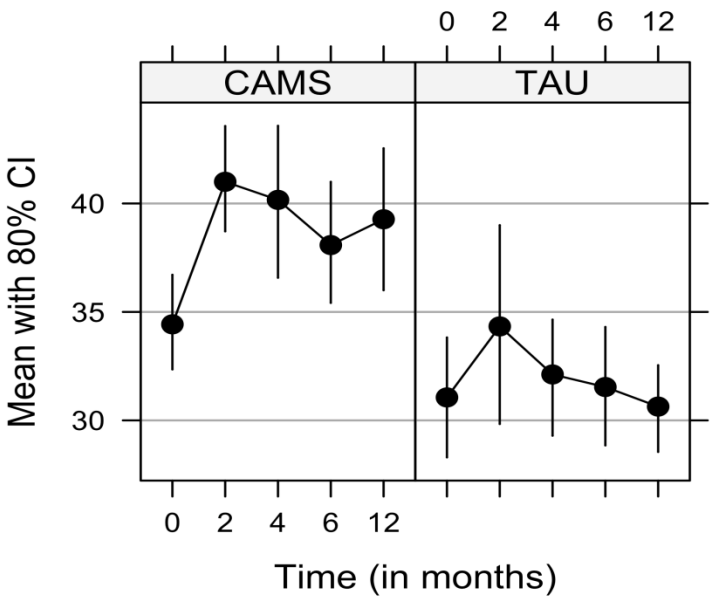
Harborview CAMS Feasibility Consort Chart



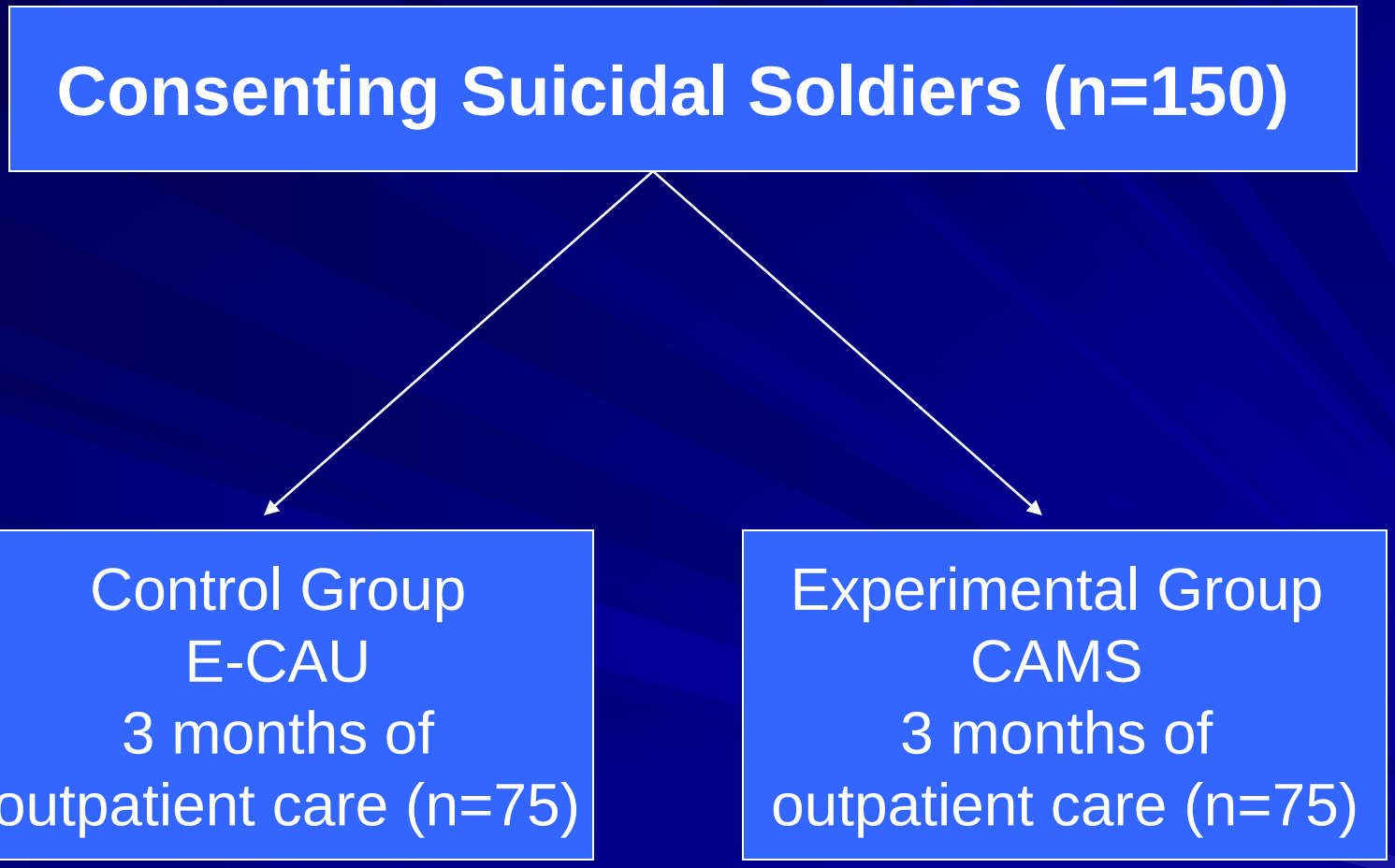

SSI
CAMS
TAU
0 2 4 6 12
Mean with 80% CI
25
20
15
10
5
0
Time (in months)


Reasons for Living
CAMS
TAU
0 2 4 6 12
Mean with 80% CI
200
180
160
Time (in months)


OQ-45
CAMS
TAU
0 2 4 6 12
Mean with 80% CI
100
90
80
70
60
50
Time (in months)


Hope Scale
CAMS
TAU
0 2 4 6 12
Mean with 80% CI
40
35
30
Time (in months)

CAMS RCT at Ft. Stewart, GA



Dependent Variables: **Suicidal Ideation/Attempts, Symptom Distress, Resiliency, Primary Care visits, Emergency Department Visits, and Hospitalizations.**

Measures: **SSI, OQ-45, SHBQ, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 months)**

Some Next Steps for CAMS

- VA E-Learning training of CAMS (Magruder, York, Marshall, & De Santis)
- VAMC use of CAMS-Groups (Johnson, Jobes, & O'Connor)
- CAMS Brief Intervention (Jobes, O'Connor, & Jennings)
- Web-based electronic version of CAMS and SSF (Koerner & Jobes)